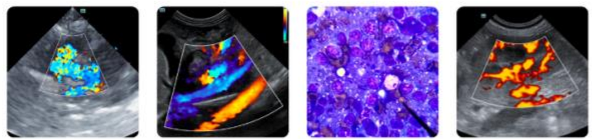


PATIENT
Clifford Hoskins

SPECIES
Feline

BREED
DMH

SEX
Neutered Male

AGE
13 Years

WEIGHT
12.12 pounds

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY
Dr. Andrea Nason

HOSPITAL NAME
Caravan Vet

REFERRING VET
Dr. Andrea Nason

INVOICE
12674

DATE
12/15/25

PRESENTING CLINICAL SIGNS

Clifford has been having waxing and waning soft to liquid stools for several months and unintentional weight loss. Abdominal ultrasound in July (report attached) had NSF. GI panel through Texas A/M in June - mildly elevated folate, rest WNL. Fecal diarrhea panel in June was unremarkable. He was started on atopica (avoiding pred due to heart disease) and seemed to respond a little but owners are having difficulty administering and he's currently off of it. He has a history of HCM stage B1/SAMM (echo in July), repeated echo yesterday/report pending. Abdominal ultrasound to evaluate for underlying causes of unintentional weight loss and abnormal stools.

Abnormal PE/Chem/CBC/UA Results: CBC - mildly elevated eosinophils (4.9) Chem - SDMA 20, Crea 1.9, BUN 25, USG 1.035, UPC 0.3 T4 1.9 Blood pressure - 152 systolic

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent particulate moderate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the left kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with mild increased echogenicity and mild indistinct corticomedullary border demarcation expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.6 cm in length.

The right kidney presented mildly enlarged in size. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with mild increased echogenicity and mild indistinct corticomedullary border demarcation expected for the age of the patient. Subtle hypoechoic subcapsular to perinephric rim and mild pyelectasia was visualized in the right kidney. The right kidney measured 4.8 cm in length.

Adrenal Glands

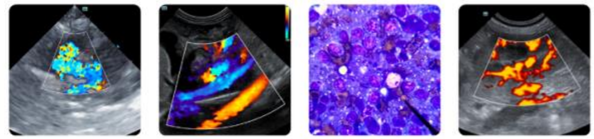
The left and right adrenal glands were not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were



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normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering. The stomach contained a moderate amount of echogenic fluid and nonshadowing ingesta/chyme. No evidence of obstruction to pyloric outflow. Pylorus wall measured 0.24 cm wall width.

The intestinal walls demonstrated intact mildly thickened wall with altered 1:3 muscularis / mucosa ratio owing to propensity for mildly thickened muscularis layer. Small intestine contained segmental to primarily generalized nonshadowing ingesta/chyme without obstruction pattern to the level of the colon. Small intestine wall measured 0.33 cm wall width.

Normal visible colon wall layers were present with lumen gas and soft fecal matter in lumen.

Pancreas

The left pancreas presented normal in size with symmetrical contour and mild nonhomogenous hypoechoic parenchyma compared to adjacent nonreactive omentum. Mildly prominent left limb pancreatic duct.

Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Nonobstructive hypomotile stomach.
- Chronic enteropathy.
- Soft fecal matter in colon.
- Possible mild left limb chronic pancreatitis.
- Urinary bladder sediment.
- Nonspecific chronic renal changes with indistinct right kidney peripheral hypoechoic halo and minor pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic IBD or other inflammatory enteropathy with potential for emerging to low-grade intestinal round cell neoplasia i.e. lymphoma is possible. The indistinct right kidney peripheral hypoechoic halo is nonspecific and may indicate concurrent unilateral/bilateral nonspecific nephritis, possible emerging right kidney neoplasia i.e. concurrent lymphoma is not definitively excluded. Urine culture and sensitivity is recommended if inflammatory sediment on urinalysis with monitoring of UPC if noninflammatory proteinuria, is recommended. Recheck GI panel to include PLI, TLI, cobalamin and folate is warranted. Assuming normal clotting status and using a 25-gauge needle, right renal cortex FNA cytology could be considered for further clarification. A definitive diagnosis would likely require intestinal biopsies for histopathology. Pending echocardiogram, gastrointestinal support i.e. dietary therapy, high colony count probiotic, cobalamin supplementation, empirical IBD protocol with clinical and sonographic monitoring of the gastrointestinal tract and right kidney is recommended.

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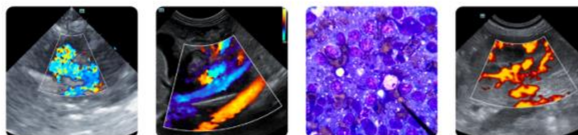

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com